***The Infant Preschool Family Mental Health Initiative (IPFMHI)***

**Brief Executive Summary**
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The California **Infant, Preschool, Family Mental Health Initiative** (IPFMHI) was funded by the First 5 California Children and Families Commission[1] through the State Department of Mental Health for two phases of work. Phase 1 (2001-2003) developed and expanded infant and early mental health services for children age birth to five and their families. Phase 2 (2003-2005) consolidated this work, developed products, identified lessons learned, and links these to the First 5 Special Needs Project.

**Phase 1: IPFMHI 2001-2003**

The State Department of Mental Health (DMH) coordinated with West Ed Center for Prevention and Early Intervention to develop and implement the project with departments of mental health and their interagency collaborators in eight pilot counties: **Alameda, Fresno, Humboldt, Los Angeles, Riverside, Sacramento, San Francisco** and **Stanislaus**. Counties were identified through and RFA process and selected for balance between urban and rural counties and for geographic distribution across the state.

Goals of the first phase of the Initiative were:

1. Initiate/expand mental health services for children 0-5 and their families.
2. Develop infrastructure, screening and assessment, and billing and funding sources, to support provision of mental health services to children 0-5 and their families
3. Expand knowledge of infant and preschool mental health, and of relationship-based services through interagency and interdisciplinary trainings
4. Expand mental health provider capacity to serve children 0-5 and their families through training, consultation and supervision of mental health clinicians.
5. Expand and strengthen interagency collaboration
6. Evaluation project activities.
7.

Five volumes of reports submitted to the First 5 California Children and Families Commission in July 2003 document initial IPFMHI activities. For Goals 1 and 2, positive outcomes for the children and families served are documented in the Clinical Services Study. For Goals 3 and 4, Participant Profiles and evaluations of training by participants document training. A manual of competencies was also developed to guide training needed to provide infant family and early mental health services. For goal 5, an Impact Evaluation documented change in practice patterns.

Evaluation (Goal 6) strategy was designed in the initial phase of the project.[2] Selection of screening tools is described below. Adoption and expansion of billing strategies to sustain activities, and of interagency collaboration to complement mental health interventions, continued past the first phase of IPFMHI, and is also described.

[1] The California Children and Families Commission, FIRST 5, was created after California voters passed Proposition 10 in 2000 (Website) Funds are distributed 20% to the State First 5 commission and 80% to County commissions in each of 58 California Counties. In 2004 the state Commission voted to combine Mental Health and Special Needs, and to consolidate efforts in the creation of 10 Special Needs Demonstration Projects.
[2] Knapp (2001) Evaluation of the IPFMHI. APPENDIX 5

**Summary of findings from phase 1:**

Goal 1 – Initiate/expand mental health services for children 0-5 and their families

A Increase in mental health services

The number of youngest children and families served by the eight pilot counties has increased by 51% from 5,850 children 0-5 and their families in fiscal year 2000-2001 to 8,842 in fiscal year 2003-2004.

Services were initiated in 2 in fiscal year 2002-2003 as part of the Initiative. The number of children served in Humboldt, a rural northern county, increased from 15 the first year to 40 the third year. In Riverside, a large southern county, the increase was from 68 the first year to 388 the third year.

B The Clinical Services Study[3] (CSS)

The CSS was a quality improvement study carried out in the eight participating counties. It s objective was too evaluate a relationship-based intervention for children aged 0-5 years in a county mental health system. Method: Screening and demographic information was obtained at intake from 388 children (mean age 34 months). Treatment was assigned by usual clinical decision, without randomization. An Index Sample (93 children) received detailed assessment at intake and after intervention (mean of 22 visits). Child psychiatric symptoms were characterized by DC 0-3 and DSM-IV, and parent child relationship by the DC 0-3 PIR-GAS. Child development was assessed with the ASQ, and parent stress/support with the PSI-SF and a Social Support Scale. Results: There were no group differences at intake between the 93 Index children and 295 children in a Clinic Reference Sample. Following intervention, GAF scores improved (effect size .35), as did the parent-child relationship (PIR-GAS effect size .16); developmental risk factors declined from 53% to 40% and at-risk scores on the ASQ for cognitive functioning declined from 38% to 13% for Index children. The percent of parents reporting overall parenting stress in the clinically significant range on the PSI/SF dropped from 51% to 42%. Conclusions: Relationship-based interventions for preschool children reduced symptoms of mental disorder, accelerated child development, improved the parent/child relationship, resources and supports, and reduced parental stress.

The Clinical Services Study Executive Summary: Development, Implementation and Preliminary Findings. prepared for CCFC, available on CCFC website, West Ed website (www.wested.org/cs/cpei/print/docs/215),or from Penny Knapp (penny.knapp@dmh.ca.gov)

Goal 2: Develop infrastructure to support provision of mental health services to children 0-5 and their families.

A Screening and assessment: Mental Health services for children served in California public Mental Health Plans (MHPs) require a DSM-IV diagnosis.[4] As the DSM-IV incompletely serves to diagnose children 0-5 with mental health disorders, a crosswalk between the DSM-IV and the DC-0-3 Crosswalk was piloted effectively to allow billing under EPSDT for specialty MH services. Also piloted by the IPFMHI were three other tools: the MHST 0-5, the Moderate Risk Assessment tool, and an Intervention Tracking tool. The Mental Health Screening Tool for Children 0-5 (MHST-0-5), which

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[3] **Feasibility of Expanding Services for Young Children in the Public Mental Health Setting**
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In review: Journal of American Academy of Child and Adolescent Psychiatry

[4] In California, specialty mental health services are provided as a carve-out from Primary Care to County Mental Health plans per MediCal (California Medicaid) waiver. To be eligible for specialty mental health services, children must meet Medical Necessity criteria. This is defined as (a) A DSM-IV diagnosis, (b) functional impairment (c) not able to be treated in primary care setting, and/or (d) a child with special health care needs or eligible for services under IDEA.

summarizes symptoms meriting mental health referral for children 0-18 months, 18-36 months, and 36-60 months. The Moderate Risk Assessment tool contains queries about contextual factors (e.g. domestic violence, parental mental illness or substance abuse) that might explain the young child's symptoms and influence treatment strategies. Major findings are summarized in **Appendix 1**.
The Intervention Tracking Tool[5] developed for this project allows providers to briefly summarize features of the clinical encounter and key clinical observations of the parent child interaction.

B Billing and funding sources: Technical assistance throughout Phase 1 allowed DMH and county Mental Health Plans (MHPs) to share strategies for maximizing funding. Major findings are summarized in **Appendix 2**.

Goal 3 Expand knowledge of infant and preschool mental health, and of relationship-based services through interagency and interdisciplinary training.

Importance: In order to extend services to a very young population not previously served, and in order to involve their parents in dyadic therapeutic work, mental health providers had to be trained to deliver services in a different way. This training occurred concurrently with the expansion of services. Training was configured in response to each county mental health plan need, as determined by ongoing need assessment and training and technical assistance.

In 2001-2003 over 200 training events, seminars, and supervision contracts, serving over 6000 participants were conducted. This work is summarized in:
Building Capacity to Provide Infant-Family and Early Mental Health services: Training, Technical Assistance, Consultation and Supervision Models.
(www.wested.org/cs/cpei/print/docs/215),

Goal 4: Expand mental health provider capacity to serve children 0-5 and their families through training, consultation and supervision of mental health clinicians.

It is a challenge to expand service in concert with expanding capacity to deliver that service. Goal 4 of the IPFMHI aimed to provide professional development for mental health professionals (Masters and PhD level), paraprofessionals, and family partners/advocates.

Continuous training and technical assistance was required to expand providers' abilities to serve a new, younger population. Importantly, the level and modality of training needed to evolve as providers in each county developed experience and skill. Reports of this work were prepared for CCFC.

At the completion of Phase 1 of IPFMHI, provider reports endorsed the value of training, and a majority indicated that continued training was desirable for their professional development as they continue to serve children 0-5 and their families.

This work is summarized in:
The Delivery of Infant-Family and Early Mental Health Services:Training Guidelines and Recommended Personnel Competencies
(www.wested.org/cs/cpei/print/docs/215)

Goal 5: Expand and strengthen interagency collaboration

Importance: Infant mental health is inherently a preventive activity. This encompasses primary (universal) prevention in the form of promotion and education, secondary (selective) prevention in the form of linking to other programs that also serve very young children and their families, and tertiary (indicated) prevention, or clinical service to infants and preschoolers, and to their families, when symptoms of a psychosocial or psychiatric disorder have become manifest. Therefore, to carry out this work, vigorous inter-agency liaison and collaboration is essential. Strategies, activities, and results have been presented to CCFC. Major findings are summarized in **Appendix 3** and **Appendix 4.**

[5] Intervention Tracking Tool **APPENDIX 5**. Data are currently being analyzed for 1042 encounters.

Goal 6: Evaluation project activities.
The evaluation logic is summarized in **Appendix 5**: Evaluation of the IPFMHI, P. Knapp 2002

***Phase 2: IPFMHI 2003-2005***

In 2003, the California First 5 Commission decided to combine Mental Health and Special Needs into a single program. The extended IPFMHI funding in 2003 – 2005 came with a shift in emphasis from supporting county mental health programs to infusing mental health skills and resources into the Special Needs project, which is built out of the First 5 School Readiness program. This phase of funding continued under the leadership of the Department of Mental Health, contracting in turn to West Ed for local assistance and for completion of phase 1 products, and to the California Institute of Mental Health (CIMH) for preparation of new deliverables, and for T/TA to the First 5 School Readiness and to Special Needs Demonstration sites, developed the 10 of Special Needs sites.

**Goals of Phase 2 were in two groups**

**A ESTABLISHMENT OF IPFMHI SERVICES IN THE PILOT COUNTIES**
**B DEVELOPMENT OF RESOURCES AND TRAINING FOR SPECIAL NEEDS PROGRAM**

In continued partnership with **West Ed Center for Prevention and Early Intervention** (www.wested/cpei.org) the project met goals to consolidate IPFMH services in the pilot counties.

1. Continue local assistance to counties for one more year to sustain clinical services and develop capacity for mental consultation to Special Needs Demonstration Sites.
2. Complete development of products based on the work of IPFMHI Phase 1. Develop a compendium of best practices for early mental health intervention.

In partnership with the **California Institute for Mental Health** (CIMH: www.cimh.org) the IPFMHI project developed new products for and provided mental health training to the First 5 Special Needs project

3. Three principal deliverables were to be prepared for use in the Special Needs Demonstration projects to be included in the Special Needs Resource Manual.)
4. Provide technical assistance and support to School Readiness programs.

The IPFMHI team worked in coordination with the T/TA coordinator for the Special Needs Demonstration project to develop materials for use in the Demonstration sites. In the Fall of 2005, each of the 10 Special Needs Demonstration sites was provided with 2-4 days of mental health consultation as they prepared programs to serve children 0-5.

***Key Findings of Phase 2:***

***A*** **ESTABLISHMENT OF IPFMHI SERVICES IN THE PILOT COUNTIES**

Phase 2 Goal 1: Continue local assistance to counties for one more year to sustain clinical services and develop capacity for mental consultation to Special Needs Demonstration Sites.
Phase 2 Goal 2: Complete development of products based on the work of IPFMHI Phase 1.
This summary of findings is prepared from a larger document: **Accomplishments and Lessons Learned** by Cindy Arstein-Kerslake, Research and Evaluation Consultant for IPFMHI.

To prepare for ongoing service to children 0-5 after State First 5 funding ceased, priorities for technical assistance were identified by the eight IPFMHI pilot counties. Principal priorities were funding

of mental health services and further training on topics related to effective practices for serving special needs children in school readiness sites. Resources were identified, including products from phase 2 of the Initiative, to address the priorities.

Continued Infant, Preschool and Family mental health programs are being sustained in the 8 pilot counties with the support of some or all of the following: (a) County First 5 funding (b) expansion of EPSDT billing (c) County MHP support, and (c) grants from foundations.

**Accomplishments with specific reference to the Phase 1 goals related to new program development:**

Expansion of mental health services for children 0-5 and their families

- **Unique approaches to capacity building and service delivery** were developed and will be sustained in each county. Examples: Alameda County's Infant Family Mental Health Seminar is now in its fourth year and will be continued. Stanislaus County focused on the use of Parent Mentors who will continue to be a part of the Stanislaus team. Los Angeles County's mental health provider network, ICARE, has grown from less than 10 to over 30 providers who meet monthly and collaborate to provide training and outreach to school readiness sites.
- **Mental health consultation services** to child care or preschool settings are provided or are being developed by all eight counties. Most counties developed or expanded those services in fiscal year 2003-2004. Riverside County Preschool 0-5 Program has mental health providers onsite at the Rob Reiner School Readiness Center. Stanislaus County Leaps and Bounds provides mental health consultation to over 30 sites in the county including preschools in the Modesto City School District and small private day care centers.
- **One or more screening or assessment** measures have been adopted for routine use in all eight counties. The most commonly adopted measures are the Parenting Stress Index-Short Form and the Diagnostic Classification for Children 0-3 (DC: 0-3).

Development of infrastructure to support provision of mental health services to children 0-5 and their families.

- **EPSDT Medi-Cal** is the primary source of funding for treatment services. Local First 5 Commission funds support mental health consultation to childcare/preschool.
- **An estimated 20% of services to families are not reimbursable** according to data from the 2001-2003 IPFMHI Clinical Services Study.
- **Evidence-based** and promising practices are being implemented by counties. Four counties are using Incredible Years; 3 counties are using Parent Child Interaction Training. San Francisco's Child Trauma Research Project developed a research-based manual for the treatment of children 0-5 exposed to trauma and violence.

Expansion of knowledge of infant and preschool mental health, and of relationship-based services through interagency and interdisciplinary training.

- **Training** is available in all counties from collaborating partners and other funding sources.
- In Phase II, First 5-identified priorities shifted from training mental health providers to providing support for providers in 10 Special Needs Demonstration Sites, planned to be developed within First 5 School Readiness sites in the state. In the needs assessment at the beginning of Phase 2, county coordinators were asked about the impact of losing training support from IPFMHI for Two counties reported no impact, as they were able to continue to provide the same ongoing training programs but with different funding sources. Six county coordinators reported that *many*

*new providers would like more training in infant and early childhood mental health and that they lacked resources to provide the same type and quality of trainings.* Nonetheless, by working *with* other collaborators to provide training activities and conferences addressing infant, family and early mental health topics, some type of training is available in all counties.

Expansion of mental health provider capacity to serve children 0-5 and their families through training, consultation and supervision of mental health clinicians.

- **County mental health is an established presence** in local meetings and committees involved with services to children birth to five and their families.
- **Reflective supervision** is an ongoing part of professional development in most county provider agencies.

Expansion and strengthening of interagency collaboration

- **Service coordination data** from the IPFMHI Clinical Services Study indicates that families are involved with from 0 to 11 other agencies with an average of 4 agencies per family. Involvement with early intervention and early childhood education agencies increases more from intake to discharge than for any other group of interagency service providers indicating the importance of mental health providers in accessing early intervention and education services for families. (IPFMHI Clinical Services Study data)
- **The greatest level of collaboration** with interagency service providers was found with other mental health intervention services (16%), Child Protective Services (16%), childcare providers (15%) and special education (14%). Collaboration including communication and consultation is particularly important with those service providers that are involved in ongoing support and or education for the child.
- **Innovative collaborations** for effective programs are described for six counties. They provide models for service delivery that might be replicated in other counties and programs. Fresno collaborates with the courts, child protective services and social services for screening, referral and assessment for all children removed from their homes. Riverside County 0-5 Preschool Program collaborates with the Department of Health and First 5 Riverside to provide county wide screening of children birth to 5 for social/emotional problems.
- **Special Needs Project Demonstration Site grants** were awarded to School Readiness programs 3 IPFMHI counties (Los Angeles, Riverside and San Francisco Counties), and to School Readiness programs in 7 other counties.
- **Materials developed by the counties** are available and may be helpful resources for mental health providers and school readiness programs.

**Summary of IPFMHI accomplishments in Phase 2, Goals 1 and 2**

Mental health services for children aged birth to five and their families have changed dramatically between 2001-2005. Integrated collaborative delivery of relationship-based interventions is thriving in all IIPFMHI eight pilot counties. The second phase of the Initiative has been successful in completing the work of the first phase and developing products and resources that will benefit developing infant and early mental health programs, school readiness sites and Special Needs Project Demonstration Sites. The experiences and accomplishments of the eight pilot counties provide unique models for integrated collaborative service delivery that address the diversity of strengths and resources within each county. The work of the Initiative is a significant contribution to the ongoing development of infant family and early mental health services in California.

## B DEVELOPMENT OF RESOURCES AND TRAINING FOR SPECIAL NEEDS PROGRAM

Phase 2 Goal 3: Three principal deliverables were to be prepared for use in the Special Needs Demonstration projects to be included in the Special Needs Resource Manual.)
Phase 2 Goal 4: Technical assistance and support to School Readiness programs.

Three manuals were prepared by CIMH, with leadership by Todd Sosna PhD, Senior Associate CIMH, and input by Ann Mastergeorge PhD, University of California Davis, and Penny Knapp MD, DMH and UC Davis.

- **Strategies for Financing Mental Health Screening, Assessment, and Services**

This 32 page document summarizes strategies for optimizing financial resources for serving mental health needs of children 0-5, interagency collaboration, funding opportunities, and lessons from the field from IPFMHI.

- **Mental Health Screening and Referral Capacity for Children 0-5**

This 31 page document summarizes stages of the screening and referral process including outreach, screening and results, monitoring and periodic re-screening, and referral and linkages to services and supports. Lessons learned from IPFMHI are summarized including interagency collaboration and screening and referral modules.

- **Compendium of Screening Tools for Early Childhood Social-Emotional Development**

This 68 page document presents characteristics of screening and assessment tools and describes 41 screening tools, with appendices and references. Screening tools used by IPFMHI counties and their evaluation of their utility is summarized.

These documents are available on the California Institute for Mental Health (CIMH) website: www.cimh.org/publications/child.cfm

- An additional document, prepared by Ann Mastergeorge PhD: **Compendium of Best Practices** presents a Literature Review of current publications on early intervention for young children. Reviewed articles are categorized by

(1) whether they are Evidence-Based, Emerging, Promising, or other practices,
(2) their domain(s) of focus: (Social Emotional, Parent-Child Relationship, Educational System, Assessment, Family, or Preventive Intervention).

An annotated bibliography provides more detail. URLs for Early Intervention and Early Childhood programs are indexed.

The document is available on the West Ed website at: (www.wested.org/cs/cpei/print/docs/215),

**Summary of IPFMHI accomplishments in Phase 2, Goals 3 and 4**
Meeting mental health service needs for children aged birth to five and their families requires expansion of existing mental health services and expansion of mental health consultation into related fields. The accomplishments and lessons learned from the California Infant Preschool Family Mental Health Initiative provide direction to achieve this expansion.

***APPENDIX 1 Screening***

*Screening and Assessment Measures*

As part of the IPFMHI Clinical Services Study from 2001-2003 to evaluate the effectiveness of relationship-based interventions for very young children and their families, county mental health providers were required to use a core set of measures with the families they served in the study. Most mental health providers had very little or no experience with the use of measures prior to their use in the Clinical Services Study. Measures were chosen based on (1) the experience of the mental health providers, and (2) their ease of administration and use by other service providers in local communities. The use of measures in the Study served the following purposes:

- Screening-To identify and describe risk factors associated with the families served.
- Assessment-To gather information that would help to guide treatment.
- Outcomes-To provide data at two points in time during treatment to evaluate the effectiveness of the treatment
- Experience-To provide experience for the mental health providers and agencies in the use of measures

Children and families served in the IPFMHI programs were screened and evaluated with measures focusing on 5 domains: Mental health, Development, Parent-child relationship, family resources, stresses and supports, and family satisfaction. The measures are shown in Table 1.

**(TABLE 1)**

| **DOMAIN** | **MEASURES** |
|---|---|
| *SERVICE*<br>Who are the clients?<br><br>1 Mental health/disorder | Child, Family Info. Packet<br>Intake Information, Referral Information<br><br>DC 0-3, DSM-IV , MHST, BABES |
| 2 Development | Ages & Stages Questionnaire<br>IDA or Bayley |
| 3 Parent-child relationship | PSI –short form<br>MIM or Early Relationship assessment |
| 4 Family Resources/ stress, supports | The Fresno Resource and Support Scale (FRSS) (Derived from Dunst scales) |
| 5 Family Satisfaction | CSQ-8<br>Infant parent program questionnaire |
| **INTERVENTION**: What did the provider do with/for the child/family? | Intervention and treatment variables<br>Intervention tracking tool |

IPFMHI strongly encouraged the continued use of measures after the completion of the Clinical Services Study. The hope was that the mental health provider agencies would incorporate some or all of the measures into their assessment process and where applicable as outcome measures later in treatment. Use of measures provides a common language for discussion of diagnosis, description of the parent child relationship, family resources and supports, developmental functioning of the child, parenting stress, and, if used as an outcome measure, change as a result of treatment.

More than a year after completion of the Clinical Services Study the pilot counties were asked about the use of measures in their counties. Data is available to show the counties' continued use of measures.

**Appendix 2: Infrastructure for services –Strategies for financing mental health services for children 0-5**

Billing and funding of both direct and indirect mental health services is of vital importance to the provision and sustainability of services to very young children and their families. The primary source of funds for direct mental health services for children ages birth to five and their families is Early Periodic Screening, Diagnosis and Treatment (EPSDT) a Federal mandate which is implemented in California for Medi-Cal beneficiaries with a General Fund match.. Billing for services under EPSDT is available for children who are full scope Medi-Cal beneficiaries between the ages of 0 and 21 and who meet criteria for medical necessity. A case must be opened and DSM IV diagnosis assigned before a provider may bill for services. The bulk of direct mental health services provided to children birth to five were billed to EPSDT Medi-Cal in all eight IPFMHI pilot counties.

Indirect mental health services to children and families are not billable. Medi-Cal. Screening of children and families in potential need of mental health services and mental health consultation services to other providers of services to children and families are examples of non-billable services. Grants from local First 5 California Children and Families Commissions have enabled County Mental Health Departments and other mental health provider agencies to significantly expand their services by providing screening and consultation services as well as mental health treatment services to children and families who don't qualify for Medi-Cal. All eight counties have local First 5 grants to support new services to children and families.

- **EPSDT Medi-Cal** is used by all eight counties.
- **Medi-Cal Administrative Activity (MAA)** is a payment source for indirect services such as consultation. It requires special billing codes and provides reimbursement at 25% of the cost of providing service. Alameda, Fresno, Sacramento and Stanislaus Counties access this source of funding.
- Health Maintenance Organizations serving Medi-Cal is indicated as a billing source for Fresno, Riverside and Stanislaus Counties.
- **Healthy Families** is a Federal insurance plan with a mental health benefit offered to families for their children 0-19 years old not eligible for Medi-Cal with family incomes below 250% of the poverty level. Fresno and Los Angeles County have had experience with this funding source.
- **Cal-WORKS** Mental Health/Substance Abuse funds are available to fund mental health services to children and families in Cal-Works programs found to be in need of additional family support. This funding source had been used by Humboldt County and to a very limited degree in Alameda, Fresno and San Francisco Counties.
- **Victim/Witness (Criminal Justice System Funds)** are available from the State District Attorney's office for mental health services to children who are victims of crime or traumatized by a crime committed toward a family member. It is a payor of last resort and has been used by Alameda and Humboldt Counties and to a lesser degree in most of the other counties.
- **Private insurance** has been accessed "often" by Alameda and Humboldt Counties, but very seldom or never by the other counties.
- **Patient fees**, usually on a sliding scale, have been a funding source for Fresno and Los Angeles Counties, but very seldom or not at all for the other counties.
- **Targeted Case Management** funds have been used by Alameda and Los Angeles Counties
- **Regional Center Funds** have been used by Alameda County to provide services to children in the Early Start program and children with developmental disabilities.
- **The California Endowment** a private source for grants for projects that support the health of California families has funded special projects in Fresno County
- **Local First 5 California Children and Families Commission** grants are used by all eight counties for special projects.

**Appendix 3: Linking children and families to community services.**

***Interagency Collaboration***

Interagency collaboration is a natural and ongoing part of the development and success of a mental health program serving very young children and their families. A principal goal of the IPFMHI initiative was to extend collaboration between county mental health programs and other programs serving children 0-5 and their families. In the 2002-2003 IPFMHI County Year End Reports, counties provided a list of key collaborating agencies. The list was updated during county visits in 2004 by the State IPFMHI Team. The types of agencies that the counties collaborate with are:

- **Mental Health Providers** including Department of Mental Health (DMH) operated agencies, DMH contracted agencies, private individual providers and private community-based provider agencies for promotion, training and service delivery.
- **Interagency Service Providers** including Early Start, regional centers, early childhood special education, childcare providers, preschools, social services, child protective services, public health and any agency that serves very young children and their families for promotion, program development, training and service coordination.
- **Infant and Early Childhood Interagency Committees and Groups** which may include the service providers listed above as well as policy groups, institutions of higher education and funding sources for the promotion and development of infant family and early mental health services, coordination, policies and training for the provision of services to children birth to 5.
- **Institutions of Higher Education** to promote the infusion of concept and values and development of course work and certificate programs in infant family and early mental health.
- **Special Funded Projects** included those funded by local First 5, California Endowment and other grants or special projects.

**Appendix 4** *Service Coordination: Findings from the Clinical Services Study*

As part of the Clinical Services Study, which evaluated the effectiveness of relationship-based treatment provided as part of the Initiative, clinicians documented the services that children and families were receiving at intake and again at discharge. They also provided an assessment of the level of collaboration they engaged in with each of the service providers the family was involved with. Highlights of the findings are below:

- The number of service providers involved with each family ranged from 0 to a high of 11 with an average of 3.9 service providers per child and family.
- The largest percentage of families were receiving services from physicians (42%), followed by Child Protective Services (33%), child care providers (30%) and other mental health intervention services from the county (24%) at intake.
- Emergency Food Assistance was added as a service for the greatest percentage of children and their families increasing from 0 to 14% from intake to discharge.
- Involvement with early intervention and early childhood education all showed increases from intake to discharge including increases from 13% to 21% for Regional Center services, 13% to 20% for preschool, special education from 12% to 17% and Early Start from 2% to 6%.
- Decreases in service provider involvement from intake to discharge were shown for health service providers including physicians 42% to 30% and public health nurses 12% to 3%.
- Involvement by Child Protective Services also showed a large decrease from 33% at intake to 24% at discharge.
- The greatest percentages of service providers with a moderate or high level of involvement with mental health providers were other mental health intervention services (16%), Child Protective Services (16%), child care providers (15%), special education (14%) and Head Start/Early Head Start (11%).

These findings provide evidence of the importance of service coordination as part of services delivered to families in need of mental health treatment services.

The increase in involvement with early intervention and early childhood education services from intake to discharge indicates that the mental health provider has a critical role in assessing special needs and helping families to access the additional services that their child may need.

The highest levels of collaboration were identified for those service providers that spend the most time with the child such as child care providers and special education or those that have provide the most intense support such as Child Protective Services. Ongoing communication and consultation between the mental health provider and other service providers facilitates relationship-based interventions within the context of the child's natural environment.

***Appendix 5***
***EVALUATION OF THE CALIFORNIA INFANT PRESCHOOL FAMILY MENTAL HEALTH INITIATIVE (IPFMHI)***
**Presented at the IPFMHI All County Meeting, 1/28,29/02 Penny Knapp MD**

*A. Goals of the IPFMHI (TABLE 1)*

| **GOAL** | **DOMAIN questions** |
|---|---|
| 1. NEW SERVICE | CHILDREN 0-5 AND THEIR FAMILIES<br>Who are the clients?<br>Do they have a mental disorder? |
| | What is their level of development? |
| | What is the quality of the parent-child relationship? |
| | What are the family's resources, stresses, supports? |
| | Will the family want/like our service? |
| | What should the intervention be? |
| 2. Service sustainability | SERVICE INFRASTRUCTURE<br>Can the new services be described? Billed for? |
| 3. TRAINING: Education of mental health/ professional community | TRAINING, CONFERENCES<br>What was taught? Who came? What did they learn? |
| 4. TRAINING: Clinician skills | SUPERVISION/CREDENTIALLING<br>What do mental health professionals need to learn to care for children 0-5 and their families? |
| 5. Interagency COLLABORATION | COORDINATION, COLLABORATION<br>What level and extent of collaboration was there at the beginning of the IPFMHI, and how did it change? |
| 6. OUTCOMES | EVALUATION<br>What evaluation(s) are necessary/possible? |

## *B. EVALUATION: What are the questions? Who wants the answers? What constitutes real information?*

**Positivist framework:**
Assumption: Quantitative (or quantifiable) data is gathered via the scientific method
e.g. double blind treatment trials, random selection of subjects, control groups, statistical analysis of results, with effect size, etc.
**Post-positivist paradigm** (Overton 1998)
Assumption: qualitative data is as meaningful as quantitative data.
Multiple possible views of truth, history and values are considered, as well as measures

**Can qualitative data be reliable and valid?**
Yes, because it provides: (Hauser-Cram et al 2000):
Breadth and depth of coverage of a problem depth of understanding across levels
Understanding of time and multiple contexts
Convergence of observations and interpretations across researchers and participations
Veridicality (accuracy) of data in context
Precision of observations

**An intervention program can be evaluated at 4 levels** (Fischer 1995):

a. Verification – the traditional scientific-technical paradigm.
Does the program fulfill its stated objectives?
e.g. Are children 0-5, with and without special needs, of several cultures, being served by the IPFMHI and are the proposed impacts being achieved?

b. Validation – Are the objectives of the program related to the identified need or problem?
e.g. Would high-risk children and families in California benefit from a relationship-based early mental health intervention?

c. Social Vindication – Does the program have value for the society, and promote commonly agreed-upon values?
e.g. Do children under 6 have mental disorders? If so, won't they grow out of them? and if they do not what would it matter to society?

d. Social Choice Framework – Utilities and rights within society.
e.g. Would it benefit society more (and/or is it more economical) to spend money on prevention and early intervention or, alternatively, on special education programs, prisons and mental hospitals to deal with persons whose early problems were not responded to?

***The IPFMHI will span verification, validation, and social vindication levels***

## *C. ASSUMPTIONS, METHOD, DESIGN: All influence evaluation*

### 1. Assumptions

#### a. Constructivist paradigm

Assumption – There are several valid important perspectives on how well a program is performing. (Guba & Lincoln 1989, Dunst, Trivett & Deal 1988), Friedman 1996)

Because early childhood programming has moved from professional-centered to parent centered models, the evaluator must produce information for staff, managers, funders, policy makers and recipients, with the goal of obtaining consensus and agreement about what is happening in the program.

#### b. Empowerment evaluation

Assumption – Recipients should be involved in conducting their own evaluations (e.g. Weiss & Green 1992).
This model discounts the deficit model, accepts the strength-based model, and lets recipients, not outside researchers, decide on criteria for success.

#### c. Participatory evaluation

Assumption - Evaluation is grounded in the experience of staff and recipients.
This model seeks to provide practical, formative and useful information to improve program outcomes.

#### d. For whom is the evaluation information obtained?

In empowerment evaluation, it is for the recipients.
In participatory evaluation it is for the providers and recipients.
In constructivist evaluation, it is for everyone.

***The IPFMHI will combine these evaluation approaches***

### 2. Methods of inquiry:

- Qualitative (holistic) or quantitative (particularistic)?
- Naturalistic or experimental?
- Contextual, cultural, comparative or "monocultural?"

Is the thing you are trying to measure a quantifiable thing, (e.g. family income) or a ***qualia*** (e.g. family relationship style)?

Or does it have both quantitative and qualitative features (e.g. I.Q measures "intelligence," but intelligence is actually how, how fast, and how well a person learns).

**Your measures will depend on how you view the thing/element you wish to measure**.

Traditional quantitative measurement strategies for young children: tests and assessments, coded observer ratings and behavioral observations.

Qualitative measurements: vignettes, analysis of observations, evaluation of interactions, context.

### 3. Design

**Mixed-methods designs: (Caracelli & Greene (1997)**
These combine scientific tradition and holistic, contextual, subjectively rich conceptions.
**Triangulation of methods:** How do results from different methodologies converge to produce similar findings?
e.g. Mental disorder: yes or no? MHST (quantitative, with cut-off scores) versus qualitative observation of the child in the context of his home.
**Complementarity of methods:** one method enhances or clarifies the results of another.
e.g. Parent child relationship assessment PSI (quantitative) and staff observation of mother and child together**.**
**Development designs:** different methods are used sequentially
e.g. screening tools and full assessment
**Initiation designs:** two methods are used to discover contradictions and paradoxical findings, to generate hypotheses.
e.g. (As we learned from the Feasibility Study,) the BABES score compared with the staff discussion with parent about how the baby as they gave the BABES.

**Expansion designs**: when either methodology is used to expand the breadth and depth of inquiry.

e.g. quantitative analyses to evaluate what part of the program is most valuable, and qualitative analyses to evaluate why it is valuable, and to whom it is valuable.

***The IPFMHI will use elements of these designs, as shown.***

## D. HOW WILL THE IPFMHI MEASURE CHANGE?

*By comparing children who received Clinical Service Study intervention with those who received usual mental health services.*

*(TABLE 2)*

| | **Mental Health Clients** (> 50 per county) | **Clinical Service Study children** (> 10/county) |
|---|---|---|
| **Intake Information** | Reason for referral,<br>MHST + Intake Information<br>And/Or<br>BABES plus supplemental | Reason for referral,<br>MHST + Intake Information<br>And/Or<br>BABES plus supplemental |
| **Subsequent care** | **Usual care, including referrals as appropriate.** | **Child enters CSS – see domains on next table** |

**For children in CSS, for each domain, these measures will be used**

***The measures will help us to quantify observations, but the clinicians' contextual, relational and subjective observations will also be recorded.***

**(TABLE 3)**

| **DOMAIN** | **MEASURES** |
|---|---|
| *SERVICE*<br>Who are the clients?<br><br>1 Mental health/disorder | Child, Family Info. Packet<br>Intake Information, Referral Information<br>MHST, BABES<br><br>DC 0-3, DSM-IV |
| 2 Development | Ages & Stages Questionnaire<br>IDA or Bayley |
| 3 Parent-child relationship | PSI<br>MIM or Early Relationship assessment |
| 4 Family Resources/ stress, supports | Dunst scales |
| 5 Family Satisfaction | CSQ-8<br>Infant parent program questionnaire |
| **INTERVENTION**: What did the provider do with/for the child/family? | Intervention and treatment variables<br>Intervention tracking |
| *PROVIDER (TRAINING)*<br>New skills: What do mental health professionals need to learn to care for children 0-5 and their families? | Participant Profile:<br>Information about the MH service provider<br>Evaluation of the Measures |
| *COLLABORATION:*<br>What level and extent of collaboration was there at the beginning of the IPFMHI, and how did it change? | Service Coordination Summary<br>(Family Information packet)<br>County Quarterly reporting |

**3. What is intervention? How will we track it?**

The **Intervention Tracking** tool allows the provider by quickly checking a short form, to record why and where the visit occurred, who was there, how long it lasted, what activities transpired, and what he/she observed.

The idea is to minimize the time spent on paperwork, yet still capture the basic facts as well as the overview of what the provider observed.

Many home visiting or early intervention programs have an educational emphasis, such as introducing educational toys and teaching the mother how to play with them with her child. Others emphasize providing information to the mother about other resources in her community. Few interventions focus on the parent-child relationship.

The relationship is a vitally important element of the IPFMHI intervention. Three items on the tracking tool seek to capture this: Attunement, Affect/Feelings of the child and Affect/Feelings of the caregiver.

Because the provider's perception is regarded as a valuable part of our information, not just the data the provider gathers, there is a final item, asking the provider to estimate progress at the time of the visit. Also, the provider may add brief written detail anywhere on the form.

## E. GOALS AND PHILOSOPHY OF THE IPFMHI EVALUATION

### 1. Is the IPFMHI program evaluable?

**a. Are our services <u>delivered in a consistent way</u>** that allows us to evaluate them in several different county systems?
e.g. is there a consistent database? Is the intervention(s) feasible?

**<u>Answer</u>:** That is why we are having the All-County meeting – to agree on basic data and how it will allow us to describe the somewhat different interventions that will occur in our clinical services study.

**b. <u>Can we define the program components</u>**?
e.g. Do we know what our goals are? Can we describe our program(s)? Do our interventions address the goals? Is our documentation adequate? Can we show how each component of the program works? Can we show how the program creates changes?

**<u>Answer</u>:** Yes. The Program participant evaluation will tell us who is doing the interventions. The Clinical services study will tell us what the interventions are. The measures we agree upon will tell us how to compare the interventions and whether they have made a change.

**c. <u>Is the program feasible</u>?**
e.g. is the information that we want available? Are the design and methodologies possible without intrusion on program processes, excessive burden on staff and participants?

**<u>Answer</u>:** Yes? We will decide on what we know we can do and what we think we can do.

**d. <u>Can we evaluate the program</u>?**
Can we collect data? Can we analyze it?

**<u>Answer</u>:** Yes. CCFC protects part of the budget for evaluation. CA DMH, the IPFMHI centers of excellence, and WestEd have the expertise to analyze and write up our findings.

### 2. Political context of evaluation

**a. <u>Sponsors of the program</u>**- what do they want to see evaluated?

Stakeholders for IPFMHI are CA Dept Mental Health and CFFC ( State Prop 10 commission)
**CA DMH:** Can mental health problems of children 0-5 and their families be reliably identified and economically served within existing budgets?
**CFFC:** Can IPFMHI provide services to children 0-5 and expand existing services to this population in California?

*a.* *Program managers and staff*

CA DMH: Can county mental health programs actually deliver services to children 0-5 and their families?

CCFC: Can Prop 10 seed monies create changes in staff skills and abilities?

*b.* *Program participants*

Will children 0-5 and their families benefit from having mental health problems identified and from their own better understanding of infant and pre-school mental health?

**d.** *Evaluators and the research and policy community*

Will the findings from the work of the IPFMHI enlarge the possibilities for early mental health intervention in ways that receive recognition in the research community and that change future policy?

**The IPFMHI evaluation uses a mixed-measure design**

**a.** **Triangulation of methods**: How do results from different methodologies converge to produce similar findings?

e.g. Mental disorder: yes or no? MHST (quantitative, with cut-off scores) versus qualitative observation of the child in the context of his home.

**b.** **Complementarity of methods**: one method enhances or clarifies the results of another. e.g. Parent child relationship assessment PSI (quantitative) and staff observation of mother and child together.

**c.** **Development designs**: different methods are used sequentially

e.g. screening tools and full assessment

**d.** **Initiation designs**: two methods are used to discover contradictions and paradoxical findings, to generate hypotheses.

e.g. (As we learned from the Feasibility Study,) the BABES score compared with the staff discussion with parent about how the baby as they gave the BABES.

**e.** **Expansion designs**: when either methodology is used to expand the breadth and depth of inquiry.

This is shown in the TABLE 4 **Design features of the IPFMHI evaluation**

(TABLE 4)

| DOMAIN | MEASURES | DESIGN |
|---|---|---|
| *SERVICE*<br><br>**1. Mental health/disorder** | Child, Family Info. Packet<br>Intake Information, Referral Information<br><br>***MHST, BABES***<br><br>***DC 0-3, DSM-IV*** | **Development**: Comparison of CSS children to general mental health population.<br><br>**Triangulation**: MHST with DC 0-3, DC 0-3 with DSM-IV |
| **2. Development** | Ages & Stages Questionnaire<br>IDA, or Bayley | **Scientific method**: measurement of development |
| **3. Parent-child relationship** | PSI<br>MIM or Early Relationship assessment | **Complementarity**: PSI is quantitative, MIM, Early Relationship assessment and clinical observation are qualitative. |
| **4. Family Resources/ stress, supports** | Dunst scales | **Scientific method**: recording, reporting.<br>Also, **Participatory evaluation** |

| | | |
|---|---|---|
| **5. Family Satisfaction** | ***CSQ-8***<br>Infant parent program questionnaire | **Scientific method**: recording, reporting.<br>Also, **Empowerment evaluation** |
| **INTERVENTION**: | Intervention and treatment variables<br>***Intervention tracking tool*** | **Initiation**: recording of details of visit combined with subtle observation and provider appraisal. |
| *PROVIDER (TRAINING)* | Participant Profile:<br>Information about the MH service provider<br>***Evaluation of the Measures*** | **Expansion:** drawing upon the CSS methodology and the provider information, the IPFMHI will expand the tools and strategies for delivering MH services in public sector to children 0-5 and their families. |
| *COLLABORATION:* | Service Coordination Summary<br>(Family Information packet)<br>County Quarterly reporting | **Scientific method**: measurement of change over time. |

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*APPENDIX 6*

# Intervention Tracking

## *Infant Preschool and Family Mental Health Initiative*

*Case #:*_____ *Date of visit:* _____

1. Who was present at this visit? Please check appropriate box(es).

| | | |
|---|---|---|
| *Participant from CIPFMHI staff* | ☐ County Mental Health<br>☐ Consultant | ☐ Child care worker<br>☐ Other: _____ |
| *Family* | ☐ Child<br>☐ Parent (Mother, Father)<br>☐ Foster Parent | ☐ Other family member(s): _____<br>_____ |

2. Where did the visit occur?
☐ Home ☐ Clinic setting ☐ Child care setting
☐ Developmental Center ☐ Park
☐
Other_____

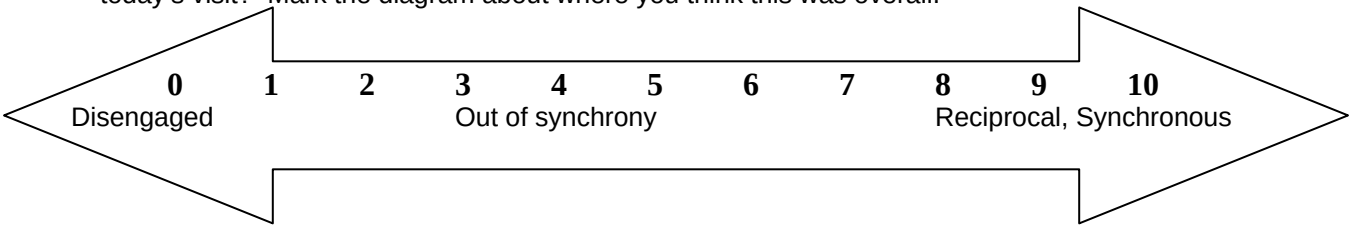
3. How long was the visit? ☐ 0-15 min. ☐ 16-30 min. ☐ 31-45 min. ☐ 46-60 min. ☐ 61-90 min.

4. Primary reason for visit: ☐ Initial Evaluation ☐ Ongoing Evaluation/Re-evaluation
☐ Ongoing Intervention ☐ Crisis Response ☐ Coordination with Others
☐ Other_____
_____

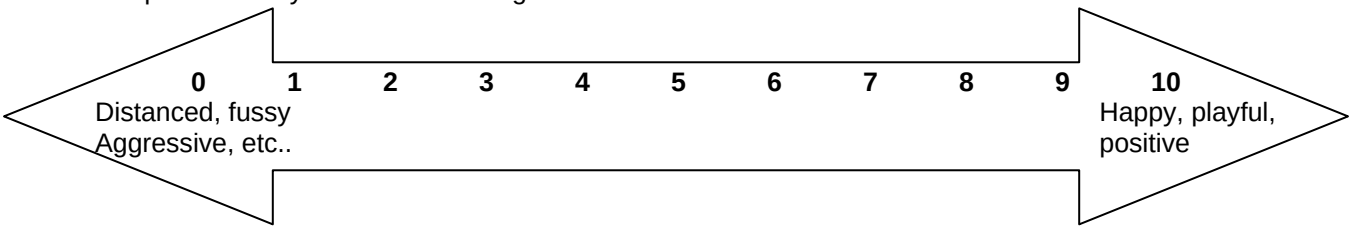
5. Modalities/Activities of Intervention: *(Check all that apply. Circle the primary intervention for this visit.)*
☐ Information gathering, assessment ☐ Parent education
☐ Parent-child relationship support ☐ Information about resources for parent
☐ Developmental ☐
Other_____

6. Anything noteworthy about today's visit? ☐ Yes ☐ No ☐ Unsure
Please explain:

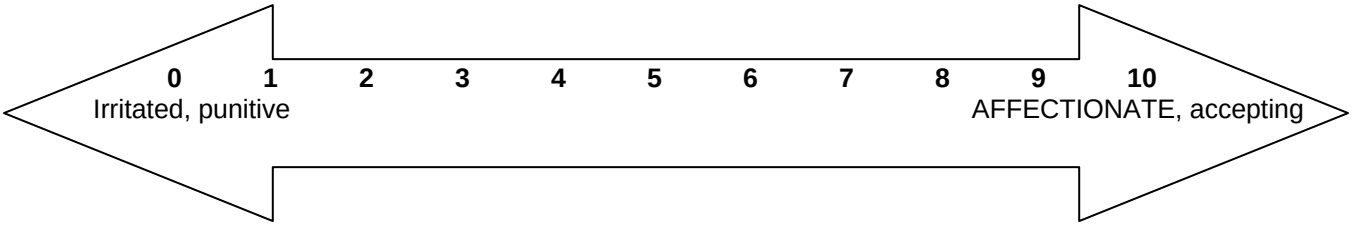
7. What is your impression about the attunement between the child and the caregiver on today's visit? Mark the diagram about where you think this was overall.



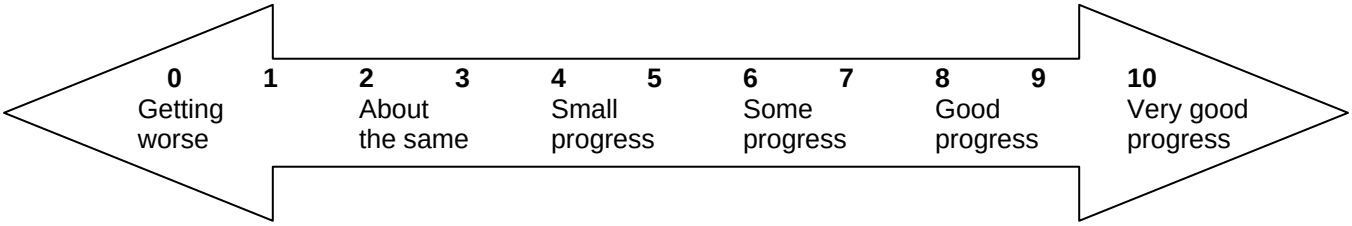
8. What is your impression about the AFFECT or FEELINGS of the CHILD on today's visit? Mark the diagram at both ends of the range that you observed during the visit, then circle the point where you think the feeling tone was overall.




9. What is your impression about the AFFECT or FEELINGS of the CAREGIVER on today's visit? Mark the diagram at both ends of the range that you observed during the visit, then circle the point where you think the feeling was overall.




10. On a scale of 10, what is your impression about the progress that is being made at the time of today's visit?




11. What change do you observe between this visit and the previous visits?